Letters to the Editor

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LETTERS

HYPERTENSION SCREENING

Sir, we have read the suggestion of Sproat and co-workers,[1] that dentists could participate in screening for hypertension, with great interest. In the Netherlands, high blood pressure screening in the dental office was also proposed, 20 years ago.[2] In a subsequent survey among 259 dentists, it was shown that if there was a financial remuneration for the procedure, 40% of the respondents replied with a definite yes, while another 40% indicated that they might take part. Without fee, only 16% said they would definitely participate and 34% said they might.[3]

The more recently graduated, the more willing the dentist was to participate in hypertension screening. The size of the practice also influenced the willingness to participate. Half of the dentists with a small practice (<500 patients) refused even when they were financially compensated *versus* only 15% of those with a larger practice (>2,000 patients).[3] In view of these Dutch results, it is interesting to explore the current opinion of UK dentists on these issues, since they may affect the implementation of high blood pressure screening in the dental office.

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ACTA

1. Sproat C, Behest S, Harwood A N, Crossbie D. Should we screen for hypertension in general dental practice? *Br Dent J* 2009: **207:** 275-277.
2. Abraham-Inpijn L, Gortzak R A T. Screening for hypertension by the dentist. *Ned Tijdschr Geneeskd* 1989; **133:** 604-606
3. Gortzak R A T, Abraham-Inpijn L, ter Horst G, Peters G. High blood pressure screening in the dental office: a survey among Dutch dentists. *Gen Dent* 1993; **41:** 246-251.

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MOUTHWASH CONTROVERSIES

Sir, in the current controversial discussion regarding the carcinogenic effects of alcohol-containing mouthwashes, the article by Werner and Seymour (*BDJ* 2009; **207:** E19; summary *BDJ* 2009; **207:** 488-489), along with the review on oral cancer by Warnakulasuriya (*BDJ* 2009; **207:** 471-475) and related commentary (*BDJ* 2009; **207:** 461), can be seen as a highlight in well-balanced and independent scientific discourse.[1-4] I fully agree with the conclusion to advise against the regular use of alcohol-containing oral products for reasons of precautionary public health protection, especially as sufficient alcohol-free alternatives are available.

Both articles[1,3] discussed the perplexing inconsistencies among the review articles, which used the same original studies as their basis. Perhaps these inconsistencies are not so surprising if we refer to the conflicts of interest or financial disclosure of the articles, however. The McCullough and Farah article,[5] which stated a cautious position, came from academia with no declared conflicts of interest. In contrast, the recent review by La Vecchia,[6] which provided a negative outcome, was conducted with 'partial unconditioned support' from Johnson and Johnson Consumer (the current maker of Listerine-brand mouthwash). Especially interesting is the re-analysis by Cole *et al.*[7] of the NCI dataset published by Winn *et al.*:[8] while the original study concluded that there is a significantly increased risk of oral cancer associated with the regular use of mouthwash, the re-analysis found this association unlikely. Cole *et al.*'s study was financially supported by Warner-Lambert Company (the former maker of Listerine). As detected previously,[9] industry-supported reviews on ethanol appear to have more favourable conclusions than the corresponding independent studies.

Besides the industry bias issue, there is a considerable amount of knowledge on mechanistic evidence and quantitative risk assessment that was only briefly mentioned in the articles. While I agree that the risk of oral cancer from mouthwash use is difficult to quantify,[1] it is not completely impossible. We have recently shown that the use of alcohol-containing mouthwashes may lead to acetaldehyde concentrations in the oral cavity of up to 105 µM, which exceeds levels that have been shown *in vitro* to form DNA adducts and cause sister chromatid exchanges. A twice-daily use of alcohol-containing mouthwashes leads to a low but quantifiable lifetime cancer risk of 3E-6.[10] The acetaldehyde burden may be increased by the cumulative exposure from a considerable number of other sources, which do not only include alcohol but also nutrition, flavourings, tobacco, and environmental exposures. The local carcinogenic effects of acetaldehyde in light of the cumulative exposure may be the molecular explanation for the link between mouthwash use and oral cancer detected in some of the epidemiological studies. It is notable that the International Agency for Research on Cancer recently upgraded acetaldehyde associated with alcohol consumption to group 1, with oesophagus, head, and neck as tumour sites with sufficient evidence for carcinogenicity in humans.[11] Nevertheless, I agree with the editorial comment[4] that the controversy around alcohol mouthwashes should not overshadow the far greater significance of alcohol drinking itself.

D. W. Lachenmeier
Germany

1. Werner C W, Seymour R A. Are alcohol containing mouthwashes safe? *Br Dent J* 2009; **207:** E19.
2. Speight P. Summary of: Are alcohol containing mouthwashes safe? *Br Dent J* 2009; **207:** 488-489.
3. Warnakulasuriya S. Causes of oral cancer - an appraisal of controversies. *Br Dent J* 2009; **207:** 471-475.
4. Hyatt A T. Diminished, sidelined. *Br Dent J* 2009; **207:** 463.
5. McCullough M J, Farah C S. The role of alcohol in oral carcinogenesis with particular reference to alcohol-containing mouthwashes. *Aust Dent J* 2008; **53:** 302-305.
6. La Vecchia C. Mouthwash and oral cancer risk: an update. *Oral Oncol* 2009; **45:** 198-200.
7. Cole P, Rodu B, Mathisen A. Alcohol-containing mouthwash and oropharyngeal cancer: a review of the epidemiology. *J Am Dent Assoc* 2003; **134:** 1079-1087.
8. Winn D M, Blot W J, McLaughlin J K *et al.* Mouthwash use and oral conditions in the risk of oral and pharyngeal cancer. *Cancer Res* 1991; **51:** 3044-3047.
9. Lachenmeier D W. Safety evaluation of topical applications of ethanol on the skin and inside the oral cavity. *J Occup Med Toxicol* 2008; **3:** 26.
10. Lachenmeier D W, Gumbel-Mako S, Sohnius E M, Keck-Wilhelm A *et al.* Salivary acetaldehyde increase due to alcohol-containing mouthwash use: a risk factor for oral cancer. *Int J Cancer* 2009; **125:** 730-735.
11. Secretan B, Straif K, Baan R *et al.* A review of human carcinogens - Part E: tobacco, areca nut, alcohol, coal smoke, and salted fish. *Lancet Oncol* 2009; **10:** 1033-1034.

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AN UNVIABLE APPROACH

Sir, I have followed the recent series of papers on the role of the dental therapist with interest. They describe attempts to follow a path trodden by the hygienists some years ago, when it was proposed to allow hygienists to set up independent practices. The laws allowing them to work without dentist supervision – and more importantly handle payments directly – were never passed. I do not remember any public debate as to why this never happened, but I suspect that when it was discovered that independent hygienists would charge the same to the patients as those working within a dental practice there was little incentive to allow full independence. The discussion of cost-effectiveness of therapists by the authors[1] goes over much the same ground. When the costs of the legally required nurse/chaperone are added to the low earning potential of a therapist working under NHS contract the whole concept of independent therapists becomes uneconomic. There is no way in which dentistry can be provided on the cheap in the UK by the equivalent of a third world 'barefoot doctor'; the regulations over how we deliver dentistry make this approach unviable. If cost control to government and patient is a priority why not ask the profession how it can be done? I am sure that many dentists would welcome a full and frank discussion and help to create a system of dental care appropriate to current conditions.

S. W. White
Shanklin

1. Williams S A, Bradley S, Godson J H, Csikar J I, Rowbotham J S. Dental therapy in the United Kingdom: part 3. Financial aspects of current working practices. *Br Dent J* 2009; **207:** 477-483.

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FAMILIAR FORCEPS

Sir, I have been interested in the advert you published recently regarding a new line of dental forceps - 'Physics Forceps from General Medical'. What fascinated me the most was the claim that these forceps were a revolutionary design using a beak and buffer principle. But are they?

Now it is a fact that I have been involved with the dental world for several decades, and casting my mind back I cannot help but notice the similarity of this revolutionary design to the robust and reliable pelican noted for its use in Cromwell's day, and also in Hampton Court some years before that to deprive Good Queen Bess of yet another troublesome tooth. All more than 400 years ago.

The Physics Forceps also bear a very close resemblance to the well known and equally robust dental extractor - the 'Tooth Key' both of which instruments also use the by now familiar beak and bumper design. If you ask the curator of the BDA Museum nicely she will no doubt show you examples of both types.

Perhaps it is well that copyright only extends for 50 years after the designer's death. Or is it possible that somewhere in an English field there lays the body of a well known tooth-puller to Lord Protector Cromwell? Maybe the marketplace tooth-puller feeling spiteful at being deprived of his 5% for the last four centuries, will arise from his grave at midnight, vampire-like, and pursue all those colleagues of mine who forgot to pay the 5% to original designer of these useful but rather outdated dental tools.

But, to those of my colleagues who have purchased these interesting Physics Forceps, and have been foolish enough not to pay the dental phantom, be warned, do not whistle at midnight under a full moon, or even cross the Grimpen Mire at night.

P. Jeavons
Sheffield

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SPIRALLING COSTS

Sir, we know that payment of a retention fee to the General Dental Council is mandatory. I did, however, enclose with it a note asking where the money was being used.

They have at least responded with a letter from a 'Process improvement Co-ordinator'. Thirty-eight percent of their 2008 expenditure was utilised on fitness to practise activity. I do therefore wonder whether the other 62% was merely used to maintain an expensive office!

To make matters worse, I now have an annual retention fee notice from the General Medical Council for £410.00. When first registering with the GMC, this was agreed to be a 'one-off payment'.

I do wonder where this is all spiralling. Perhaps you will publish my concerns, in order that colleagues may have the opportunity of joining with me in a response to these now non-professional bureaucracies.

B. Littler
Chelmsford

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CAVALIER ATTITUDE

Sir, over the years I have prescribed Adcortyl in Orabase (triamcinolone acetonide 0.1%) for patients with recurrent oral ulceration. More recently it has been available as an 'over the counter' medicine.

I have been told by a number of patients that it is no longer available as it has been withdrawn. They could obtain no further information.

This prompted me to make enquiries on their behalf. I visited the DPF website where Adcortyl in Orabase is still listed.

I then contacted the manufacturers, Squibb Pharmaceuticals, who informed me that it had been withdrawn for 'commercial reasons'. When I asked how that